San Diego County Black Infant Health (BIH) Program

4725 Market Street • San Diego, CA 92102

REFERRAL FORM

Please fax completed form to Barbara Greer at (619) 262-9188
OR e-mail to barbarag@fhcsd.org

PLEASE PRINT CLEARLY

PLEASE NOTE: BIH program eligibility requirements have changed. BIH accepts only African American women who are PREGNANT.

❒ **Yes, client is a pregnant African American woman**

Baby's Due Date: _____/_____/_____

Last Name:	**First Name:**	**Nickname/AKA/Maiden:**
Street Address:	**City:**	**Zip Code:**
Home Phone Number:	**Cell Phone Number:**	
Email Address:	**Date of Birth:** _____/_____/_____	
Additional Information:		

By signing below, I agree to be contacted by the San Diego County Black Infant Health Program.

Client/Patient Signature: _____ Date: _____

SOURCE OF REFERRAL TO BIH

Referral Date: _____/_____/_____

Name: _____

Organization Name: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Thank you for your referral to the BIH program.
For more information about BIH program services, please call (619) 266-7466.

The San Diego County Black Infant Health (BIH) Program receives funds from the State of California, Department of Public Health, Maternal, Child, and Adolescent Health Division through the County of San Diego, Health and Human Services Agency and First 5 Commission of San Diego. The San Diego County BIH Program is operated in San Diego County by Family Health Centers of San Diego.